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No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1974

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

APPENDICES TO RESPONDENT'S BRIEF

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APPENDIX A

LACK OF COMPETITION IN THE DRUG INDUSTRY

Excerpts from the hearing on *Small Business Problems in the Drug Industry* by the Subcommittee on Activities of Regulatory Agencies of the Select Committee on Small Business, House of Representatives, 90th Congress, First Session (1967-8) pursuant to H. Res. 53.

References to the absence of true price competition in the pharmaceutical industry are found on the following pages: 194, 197, 205, 206, 207, 246, 294, 304, 308, 309, 313, 318, 319.

The following colloquy appears on p 194 between the committee's counsel (Potvin) and one of New York's largest wholesale druggists (Jack Mandell):

"MR. POTVIN: But in those areas where there are only full-line wholesalers, is it not a fact, sir, that price competition is regarded by most observers to be totally absent?

"MR. MANDELL: For many years it was."

Also on page 197:

"MR. POTVIN: (A)s the late Senator Kefauver so well established, price competition between manufacturers is rather less than vibrant in your industry as well; is it not?

"MR. MANDELL: Yes, I would say that sir."

Another wholesaler (Hyman Moore of New Britain, Connecticut) was asked (1c319):

"MR. POTVIN: Are you saying, sir, than that as concerns the community pharmacist, manufacturers do not engage in price competition with each other?

"MR. MOORE: Very rarely . . . I have heard stuff about incremental costs and so forth and so on, and incremental costs for selling merchandise for export. I personally think that is a lot of hogwash. I think prices are lower to hospitals, I think prices are lower for export, I think prices are lower in city and county, State governments because there is competition in those areas. I think they make a profit when they take something like prednisone and instead of $170, they go down to $4, or whatever it is, I think they are making a profit on that price. They consider it plus business. I think they are selling merchandise for whatever the traffic will bear, they are getting as much as they can for what they can. I do not see why prices should be lower for export than things brought here. I don't know that any foreigner's money is better than mine or Mr. Average Consumer's.

"I do know there is competition. I do know there are pharmaceutical industries in these countries that are quite well developed and American manufacturers have to meet them. They don't have to meet them here. Otherwise, you could not take common generic products that cost just a few pennies and keep the price at $22.60 a thousand, which has been as long as I have been in the business, which is 20 years."

At the conclusion of the hearings the Subcommittee, after considering other evidence of "possible

parallel pricing practices," concluded (A Report of Subcommittee No. 5 to the Select Committee on Small Business, House of Repr., 90th Congress, 2nd Sess. [1968] 77 [H.R. 1983]):

"There is little or no price competition in the marketing of trademarked pharmaceutical products among manufacturers.

. . .

"More vigorous action is required at the earliest possible time on the part of the Federal Trade Commission to enforce the Robinson-Patman Act and other statutes administered by it if small business drug wholesalers and retail pharmacists are to continue their important role in serving the Nation's health needs."

And that (1c 80):

"As pointed out herein above, there is an almost total absence of the usual type of price competition in the marketing of trademarked pharmaceuticals."

An article in 53 Virginia L.R. 1285-6 (1967) stated:

"As a result one might expect the prices of ethical drugs to be established by individual manufacturers largely on the basis of their cost functions, and without reference to the prices charged by competitors. Since the production and promotional costs of sellers are quite likely different, their prices should reflect this difference. However, where major producers are concerned, this is frequently not the case."

Another example of the lack of price competition in the U.S. drug industry appears in the Congressional Record, September 29, 1972, where Senator Gaylord Nelson stated:

> "The price of 100 tablets of propoxyphene, Darvon, sold by the Lilly Co. to the druggist in the United States is $7.02, but the price charged by the same company for the same product in Ireland is $1.66, and in the United Kingdom is $1.92. Bristol charges $21.84 for 100 tablets of ampicillin in the United States, but $9.31 in Ireland; Ciba charged $3 for glutethimide, Doriden, in the United States, but 92 cents in Ireland, $1.23 in New Zealand, and $1 in the United Kingdom. The Pfizer Co. charges $20.48 in the United States for oxytetracycline, Terramycin, but $4.63 in Brazil and $3.68 in New Zealand. These are only a few examples of discrimination against the American people."

See also Green, *The Monopoly Makers* 257-285 (1973); Kefauver, *In a Few Hands (Monopoly Power In America)* 8-79 (1965). Also *U.S.* v. *Parke, Davis & Company*, 362 U.S. 29 (1960) (Parke, Davis was recently absorbed by petitioner Carter-Wallace, Inc.); *William H. Rorer, Inc.* v. *Federal Trade Commission*, 374 F.2d 622 (2nd Cir. 1967); *U. S.* v. *Carter Products, Inc. and American Home Products*, 211 Fed. Supp. 144 (S.D. N.Y. 1962); *U. S.* v. *Ekco Products Company and Ekco-Glaco Company*, 1966 Trade Cases ¶ 71,764 (U.S. D.C. N.D. Cal. 1966) (both Ekco Products and Ekco-Glaco are divisions of defendant American Home Products Corporation; *U. S.* v. *Fisons Ltd., Fisons Pharmaceuticals, Ltd., Colgate-Palmolive, Armour & Co. and American Home Products Corp.*, 1972 Trade Cases ¶ 73,794 (U.S.D.C. N.D. Ill. 1972); *In re Antibiotic Antitrust Actions*, 333 F. Supp. 267 (S.D. N.Y. 1971) (defendants include Bristol-Myers and Squibb).

APPENDIX B

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APPENDIX B

ILLUSTRATIVE COMPARATIVE PRICES CHARGED HOSPITALS AND RETAIL DRUGGISTS*

Manufacturer	Drug	Reference	Quantity	Price to hospitals	Price to druggist
Abbott Laboratories	Penicillin V Potassium 125 mg	R730	100	$ 1.95	$ 5.37
	Hydrochloro-thiazide 50 mg	R730	1000	29.50	41.18
	Erythromycin ethyl succinate 200 mg	R730	50	8.55	9.00
American Home Products	Omnipen 250 mg 8-55-1 5 cc	R731	80 ml bottles	.79	2.26
	Omnipen 8-315-6 500 mg vial	R731	10	2.50	19.00
	Omnipen 8-315-9 1000 mg vial	R731	10	4.50	26.00
American Home Products (Cont.)	Equanil 1R481 400 mg	R731	500 1000	12.36 24.50	29.50 58.00
	Bicillin LA 6000MU tubex pkg of 10	R731-732	1-9 10-99	8.75 8.00	13.46 12.08
	Bicillin LA 1200MU tubex pkg of 10	R731-732	1-9 10-99	15.00 14.00	23.24 20.92
Bristol-Myers Company	Erythromycin 250 mg base Bristamycin	R731	100	7.24	9.48
	Amphycillin 250 mg	HR 1983 90th Cg. 12	100	11.96	27.25
Wm. H. Rorer, Inc.	Ananase	Connerty 38	50	5.76	6.12
Squibb	Neomycin sulphate tablets	HR 1983 90th Cg. 12	100	5.20	20.54
	Principen-N #9716		500	17.40	60.67

*See also brief p.14.

Manufacturer	Drug	Quantity	Price to hospitals	Price to druggist
Squibb (Cont.)	Principen-N #9715	100	3.85	12.67
	Principen-N #9745	100	6.50	24.83
	Principen-N #97451	100	6.75	24.83
	Sumycin #6556	1000	13.75	38.50
	Sumycin #65546	100	1.75	4.25
	Sumycin #7634	100	3.15	8.25
	Sumycin #76346	100	3.50	8.25
	Sumycin #8156	60 ml	.42	.90
	Sumycin #8155	480 m.	1.98	4.95
	Penicillin #6346	50	5.88	10.50
	Penicillin #67374	25	6.50	22.50
	Penicillin #7341	per each	.55	1.80
	Penicillin #7353	per each	1.05	3.20
	Penicillin #6846	100	1.99	7.05
Squibb (Cont.)	Penicillin #6384	100	3.95	12.68
	Penicillin #6814	bottle	.49	1.30
	Penicillin #6824	bottle	.69	1.68
	Pentids 300		5.25	6.25
	Pentids P 600 A.S.		5.50	8.25
	Delestrogen 20 mg/cc	per dose (50 doses)	1.22	1.50
	Noctec 7½ gr		2.00	4.20
	Principen 250 mg cap		25.00	91.00
	Principen 500 mg cap		9.25	37.25
	Principen Powder 12		.60	2.18
	Deladuomone 2 cc Unimatic		2.44	2.84
	Sumycin Hydrochloride		168.00	180.00

APPENDIX C

TABLE 1. COMPARISON OF SELECTED PHARMACEUTICAL PRICES IN THE UNITED STATES AND EIGHT FOREIGN COUNTRIES, JANUARY 1970*
(All prices in U.S. dollars for 100 tablets or capsules)
Price to druggist, brand name, and manufacturer

Generic Name	United States	Australia	Brasil
Analgesic: Propoxyphene HCl (65 mg)...	$7.02, Darvon, Lilly.	$2.73, Doloxene, Lilly.	$3.72, Doloxene, Lilly.
Antibiotics:			
Ampicillin (250 mg)	$21.84, Polycillin, Bristol.	$20.48, Penbritin, Bristol.	$41.95, Polycillin, Bristol.
Demethylchlorletracycline HCl (150 mg)	$19.79, Declomycin, Lederle.	$11.17, Ledermycin, Lederle.	$4.93, Ledermicina, Cynamid Quim de Brasil.
Erythromycin (250 mg)	$26.12, Erythrocin, Abbott.	$14.51, Erythrocin, Abbott.	$11.92, Pantomicina, Abbott.
Oxytetracycline HCl (250 mg)	$20.48, Terramycin, Pfizer.	$9.79, Terramycin, Pfizer.	$4.63, Terramicina, Pfizer.
Potassium phenoxymethylpenicillin (250 mg)	$8.95, V-Cillin-K, Lilly.	$6.11, P.V.K., Lilly.	$8.66, V-Cil-K, Lilly.
Tetracycline HCl (250 mg)	$5.34, Achromycin-V, Lederle.	$9.79, Achromy-cin-V, Lederle.	$4.22, Achromy-cin-V, Cynamid Quim de Brasil.
Antidepressant: Amitriptyline HCl (25 mg)	$8.55, Elavil, Merck.	$8.33, Tryptanol, Merck.	$2.26, Tryptanol, Merck.
Antidiabetic: Tolbutamide (500 mg) ...	$8.23, Orinase, Upjohn.	$2.83, Rastinon, Hoechst.	$2.77, Rastinon, Hoechst.
Antihistamine: Diphenhydramine HCl (50 mg)	$2.22, Benadryl, Parke-Davis.	$1.60, Benadryl, Parke-Davis.	$0.81, Benadryl, Parke-Davis.
Ataraxics (tranquillizers):			
Chlordiazepoxide HCl (10 mg)	$6.40, Librium, Roche.	$3.74, Librium, Roche.	$2.40, Librium, Roche.
Chlorpromazine HCl (50 mg)	$6.60, Thorazine, SKF.	$2.22, Largactil, May & Baker.	$2.47, Amplictil, Rhodia.
Diazepam (5 mg)	$8.03, Valium, Roche.	$3.74, Valium, Roche.	$3.62, Valium, Roche.
Meprobamate (400 mg)	$7.06, Equanil, Wyeth.	$4.17, Equanil, Wyeth.	$1.91, Equanil, Wyeth.
Prochlorperazine maleate (10 mg) ...	$7.86, Compazine, SKF.	$4.44, Stemetil, May & Baker.	$2.45, Temertil, Rhodia.
Trifluoperazine HCl (5 mg)	$9.75, Stelazine, SKF.	$4.70, Stelazine, SKF.	$2.42, Stelazine, SKF.
Cardiovascular: Digoxin (.25 mg)	$1.03, Lanoxin, B-W.	$0.69, Lanoxin, B-W.	$1.31, Digoxina, B-W.
Oral contraceptive: Ethynodial diacetate with mestranol (6x21 tabs, 1 mg)	$7.38, Ovulen 21, Searle.	$4.11, Ovulen 21, Searle.	$4.82, Ovulen 21, Searle.
Sedative: Glutethimide (250 mg)	$8.00, Doriden, Ciba.	$2.11, Doriden, Ciba.	$1.97, Doriden, Ciba.
Sulfonamide: Sulfisoxazole (50 mg) ...	$2.94, Gantrisin, Roche.	$3.00, Gantrisin, Roche.	$1.51, Gantrisin, Roche.

Canada	Ireland	Italy	New Zealand	Sweden	United Kingdom
$5.29, Darvon, Lilly.	$1.66, Doloxene, Lilly.	$7.86, Doloxene, Lilly.	$2.08 Doloxene, Lilly.	$3.33, Doloxene, Lilly.	$1.92, Doloxene, Lilly.
$22.18, Ampicin, Bristol.	$9.31, Pentrexl, Bristol.	$19.15, Sintoparyl, Aesculapius.	$11.30, Penbritin, Beecham.	$16.58, Pentrexyl, Bristol.	$8.23, Penbritin, Beecham.
$16.09, Declomycin, Lederle.	$8.87, Ledermycin, Lederle.	$17.88, Ledermicina, Cyanamid.	$3.87, Ledermycin, Lederle.	$19.43, Ledermycin, Lederle.	$8.20, Ledermycin, Lederle.
$25.04, Erythrocin, Abbott.	$8.56, Erythrocin, Abbott.	$24.57, Eritrocina, Abbott.	$10.88, Official Price.	$19.21, Erthromycin, Abbott.	$10.02, Erthromycin, Abbott.
$16.92, Terramycin, Pfizer.	$7.74, Terramycin, Pfizer.	$13.27, Terramicina, Pfizer.	$3.68, Official Price.	$13.04, Terramycin, Pfizer.	$9.06, Terramycin, Pfizer.
$10.69, V-Cillin-K, Lilly.	$2.77, Penicillin-V, Lilly.		$2.99, Official Price.		$2.40, V-Cil-K, Lilly.
$12.64, Achromy-cin-V, Lederle.	$3.42, Achromy-cin-V, Lederle.	$10.84, Achromy-cina, Lederle.	$13.73, Achromy-cin-V, Lederle.	$13.89, Achromy-cin-V, Lederle.	$5.04, Achromy-cin-V, Lederle.
$6.30, Elavil, Merck.	$2.26, Tryptisol, Merck.	$4.22, Triptisol, Merck.	$4.20, Tryptanol, Merck.	$3.09, Tryptisol, Merck.	$2.20, Tryptisol, Merck.
$6.34, Orinase, Hoechst.	$2.22, Rastinon, Hoechst.	$2.86, Rastinon, Hoechst.		$4.86, Rastinon, Hoechst.	$2.28, Rastinon, Hoechst.
$2.77, Benadryl, Parke-Davis.	$1.37, Benadryl, Parke-Davis.	$2.80, Benadryl, Parke-Davis.	$1.29, Official Price.	$2.33, Benadryl, Parke-Davis.	$1.20, Benadryl, Parke-Davis.
$5.45, Librium, Roche.	$2.05, Librium, Roche.	$3.55, Librium, Roche.	$1.83, Librium, Roche.	$3.11, Librium, Roche.	$2.40, Librium, Roche.
$5.82, Largactil, Rhone-Poutenc.	$1.71, Largactil, May & Baker.	$3.47, Largactil, Farmitalia.	$1.82, Official Price.	$2.88, Largactil, Rhodia.	$1.68, Largactil, May & Baker.
$6.01, Valium, Roche.	$2.46, Valium, Roche.	$3.42, Valium, Roche.	$2.72, Official price.	$3.71, Valium, Roche.	$2.88, Valium, Roche.
$5.13, Equanil, Wyeth.	$1.79, Equanil, Wyeth.	$3.65, Quanil, Wyeth.	$2.06, Official price.	$1.67, Equanil, Farrosan.	$1.74, Equanil, Wyeth.
$6.05, Stemetil, Rhone-Poutenc,	$2.87, Stemetil, May & Baker.	$3.04, Stemetil, Farmitalia.	$2.93, Official Price.	$2.28, Stemetil, Leo.	$3.04, Stemetil, SKF.
$8.38, Stelazine, SKF.	$2.78, Stelazine, SKF.	$3.82, Modalina, Maggioni.	$3.71, Official Price.	$4.41, Terfluzin, Rhodia.	$2.59, Stelazine, SKF.
$1.51, Lanoxin, B-W.	$0.53, Lanoxin, B-W.	$1.73, Lanoxin, Wellcome.	$0.52, Official Price.	$0.98, Lanoxin, B-W.	$0.38, Lanoxin, B-W.
$5.85, Ovulen 21, Searle.	$3.59, Ovulen 21, Searle.	$8.20, Ovulenl Leptit.	$3.56, Official Price.	$4.51, Ovulen 21, Searle.	$4.10, Ovulen 21, Searle.
$2.76, Doriden, Ciba.	$0.92, Doriden, Ciba.	$1.80, Doriden, Ciba.	$1.23, Officela Price.	$2.05, Doriden, Ciba.	$1.00, Doriden, Ciba.
$3.06, Gantrisin, Roche.	$1.64, Gantrisin, Roche.	$2.47, Gantrisin, Roche.	$1.11, Gantrisin, Roche.	$2.83, Gantrisin, Roche.	$1.52, Gantrisin, Roche.

* Social Security Bulletin, May, 1971 - Vol. 34, No. 5, U.S. Department of Health, Education & Welfare, S.S. Administration; p. 170-171, 967.

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APPENDIX D

NEIGHBORHOOD DRUG STORE PHARMACIES SHOULD BE PRESERVED. IN MANY RESPECTS THEY ARE SUPERIOR TO HOSPITAL PHARMACIES, AND THE CONSUMER SHOULD HAVE THE OPTION TO PATRONIZE THEM IF HE WISHES

There are values worth preserving in corner drug stores. For example:

(a) Drug store pharmacies must be operated by trained and licensed pharmacists,[1] while many hospital drug rooms are staffed by nonpharmacist technicians and clerks.[2] Much hospital dispensation is done by nurses at nursing stations throughout hospitals.[3] Studies have shown that approximately one in six or seven of all medications so dispensed in hospitals is wrong.[4]

[1] Or. Rev. Stat. 689.310: Neighborhood pharmacies are required to comply with the state's Pharmaceutical Services Guide, and are audited by the state and federal government to insure compliance (R. 810).

[2] Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy* (1964) 68; Fleissner 15; Hastings 13.

[3] Greenlick dep. ex. no. 3, Johnson & Christensen, A Report of The Kaiser Foundation Drug System (1971), 159 (many medication preparation areas are not isolated, but in the central, busiest areas on hospital floors); 155 (32% of the nurses rated hospital drug storing procedures as bad or very bad); 47 (the nursing department assumes responsibility for nearly all inpatient drug distribution, including interpreting and transcribing physicians' drug orders, floor stock drug ordering and receiving, and preparation and administration of individual doses); 174 (no systematic screening of personnel involved in the inpatient drug service system).

[4] Ibid., fn. 3, 262; Tester, William W., A Report of the Iowa Drug Distribution System, *Drug Intelligence, II*, Nov. 1968, pp. 305-309; Stewart & Cluff, A Review of Medication Errors and Compliance in Ambulant Patients, *13 Clinical Pharmacology and Therapeutics* (July-August 1972) 463, 465; Barker & McConnell, How to Detect Medication Errors, 99 *Modern Hospitals* 95-106 (1962).

(b) Respondent agrees there is a problem in getting the patients to follow prescribed drug regimen.[5] However, studies have also shown that patient compliance increases where there is oral contact between pharmacist and patient.[6] There is a greater likelihood of this between the neighborhood pharmacist than in the clinical hospital pharmacy environment.

(c) There are still many hospitals having no pharmacists.[7] Such is not the case with drug stores, where a trained pharmacist must be employed.[8]

(d) If drug store pharmacies are phased out it will be necessary to obtain medication from the hospital. This may mean considerable travel. Studies at Kaiser Hospital have indicated the average travel time is approximately 18 minutes to reach the hospital pharmacy.[9]

(e) Many hospital pharmacies are cramped. Some lack recommended equipment.[10] There have

[5] Marston 19, *Nursing Research* 312 (1970).

[6] Sharpe & Mikeal, Compliance with Medical Regimens, *31 Am. Journal Hospital Pharmacy* (1974) 479, Patient Compliance with Antibiotic Regimens.

[7] Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy* 68 (1964); Fleissner 15; Hastings 13.

[8] Ibid., fn. 1.

[9] Ibid., fn. 3, 480.

[10] Francke, Latiolais, Francke & Ho, supra, 67 (more than 50% of the nation's pharmacies in hospitals with 200 or more beds, including more than 500 hospitals with from 300 to more than 500 beds, do not have the space or equipment recommended by the Public Health Service for the pharmacy in a 200-bed hospital. This is also true of hospitals

also been complaints of extended waiting.[11]

(f) There is no certainty that if drug stores disappear, costs will not increase at hospital pharmacies. Average cost of treatment in hospital outpatient clinics is nearly twice as much as that in a private physician's office.[12] There is also no assurance the doctor one sees at the hospital is superior to the doctor one might see in his own neighborhood. Approximately 15% of the nation's hospital physicians are interns or residents;[13] 35% of these are recruited from abroad, where their training is often inferior to that in the U.S.[14]

The American pharmacist is a resource of inestimable value, whose talent has not yet been fully tapped.[15] It has been said that the pharmacist is the

with 100 beds.); Somers, *119 Mod. Hospital* 95 (June 1972) ("Some [hospitals], especially some of our big city municipal institutions, are incredibly poor.")

[11] Bodenheimer, *VII Inquiry* 26, 33 (Sept. 1970); Ibid., fn. 41, 486; Hearings, supra, 179.

[12] Editorial, The Hospital's Responsibility for Primary Care, *2 Hosp. Med. Staff* (Jan. 1973) at 1.

[13] Knowles, The Hospital, *Scientific American* 128, 135 (Sept. 1973).

[14] Ibid.

[15] Brodie & Graber, Institutional Pharmacy in the 1970's, 28 Amer. Journal of Hospital Pharmacy 240, 243-4 (1971) ("if the pharmacists' present background were supplemented with specialized training, a large unexplored area of service would undoubtedly be opened up. The pharmacist is usually the next best educated person in the hospital, second only to the physician, and yet he is usually poorly used. It is only reasonable to believe that some pharmacists—*either in or out of the hospital*—will be shifted into areas of service made critical by the physician shortage. One has only to reflect on the fact that there are 35,000 pharmacists in the United States who graduated from pharmacy school since 1960 to realize the potential that this reservoir has for relieving

second best educated person in hospitals.[16] The educational backgrounds of neighborhood pharmacists and hospital pharmacists are identical.[17]

While we are being reminded that we face a severe physician shortage,[18] and serious proposals are being made to reduce the education required for physicians from 8 to 6 years,[19] petitioners are impliedly suggesting we can well dispense with neighborhood pharmacists.

It is dubious that hospitals are fully prepared to handle the crunch which will surely follow if the 1½ billion prescriptions which are being filled at drug stores[20] are suddenly shifted to hospital pharmacies. Many hospital parking lots are crowded now. Moreover, the hours of operation at hospital pharmacies may not be as advantageous as those offered at drug stores. Some close at 5:00 p.m.[21] Others are not open on Sundays, etc.[22] Can we be sure that those who urgently need medications will receive help in time if there is no corner drug store?

Drug stores are not always open either. But al-

some of the problems created by the physician shortage.") (Underlining supplied).

[16] Hearings, supra, 131 (Hospital pharmacists have the same academic background, and same number of hours in pharmacy school.); see fn. 15, supra.

[17] Fn. 16, supra.

[18] Brodie & Graber, supra, 245 (discussing the Carnegie Commission's recent report.)

[19] Ibid.

[20] Gosselin, *West Coast-Rocky Mountain Druggist* (July 1975) 29.

[21] Chartier, 15; Neal, 10.

[22] Chartier, 15; Neal, 10.

most all in Portland offer emergency home delivery to those with an immediate need.[23] There is no indication that any of the hospital pharmacies in Portland do so.

In addition, if drug stores fade and are replaced by those operated by nonprofit hospitals, the tax revenue generated by drug stores will fade too. Do hospitals, which pay no taxes, need drug price favoritism as well when they have no intent to use such drugs for hospital uses?

The average drug store pharmacy carries many more items than those carried by hospital pharmacies.[24] Most hospitals use a formulary, which means that the drugs stocked are confined to those listed on the formulary.[25] Many physicians have expressed their displeasure and have preferred community pharmacies for that very reason.[26]

It has also been noted that where hospitals engage in extensive filling of prescription for nonpatients, these are the ones which are often filled first, rather than the more acute inpatients.[27]

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[23] R. 646.

[24] There are, for example, more than 170,000 separate items listed in the Red and Blue Books, the standard catalogues in the industry (Hearings, supra, 341), though most neighborhood pharmacies carry only 3000 drugs. (Hearings, supra 130). At that, however, it is still more than the average of 300-400 drugs carried by some hospital pharmacies. (Merrill, *Hospitals* (June 1941) 33-34).

[25] Merrill, *Hospitals* (June 1941) 33, 34.

[26] Dr. Merrill has written (Hospitals 33, 34 (June 1941)): "A formulary of limited scope and standardized preparations cannot contribute to this desirable practice and would restrict the physician to substandard treatment."

[27] Ibid., fn. 3, 51.